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STATE OF MICHIGAN
IN THE SUPREME COURT

REBECCA GROSSMAN, as Personal Representative of the Estate of FRED GROSSMAN, Deceased,

Plaintiff-Appellee

vs.

OTTO W. BROWN, M.D., SINAI HOSPITAL, an assumed name of SINAI HOSPITAL OF GREATER DETROIT, a Michigan non-profit corporation,

Defendants-Appellants

and

ROBERT MURRAY, M.D.,

Defendant

Supreme Court No. 122458
Court of Appeals No. 242241
Lower Court No. 01-113249-NH

EILEEN HALLORAN, Temporary Personal Representative of the ESTATE OF DENNIS J. HALLORAN, Deceased,

Plaintiff-Appellee

vs.

RAAKESH C. BHAN, M.D., and CRITICAL CARE PULMONARY MEDICINE, P.C.,

Defendants-Appellants

and

BATTLE CREEK HEALTH SYSTEMS,

Defendant

Supreme Court No. 121523
Court of Appeals No. 224548
Lower Court No. 98-3953-NH

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AMICUS CURIAE BRIEF OF MICHIGAN STATE MEDICAL SOCIETY

PROOF OF SERVICE

KERR, RUSSELL AND WEBER, PLC

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JURISDICTIONAL STATEMENT

Amicus Curiae Michigan State Medical Society relies upon the jurisdictional statements of the parties to these appeals.

STATEMENT OF QUESTIONS PRESENTED

Whether MCL 600.2169 requires that the specialties and board certifications of a plaintiff's standard of care expert match the specialties and board certifications of the defendant, including the following sub-issues:

a. Whether a standard of care expert witness is qualified under MCL 600.2169(1)(a) to present expert testimony against a defendant physician where the proffered witness does not possess the same certificate of special qualification as the defendant physician?

Amicus Curiae MSMS says "no."

b. Whether a standard of care expert witness is qualified under MCL 600.2169(1)(a) to present expert testimony against a defendant physician where the proffered witness does not possess the same board certification as the defendant physician?

Amicus Curiae MSMS says "no."

c. Whether the word "specialty" in the first sentence of MCL 600.2169(1)(a) should be construed to refer to the specialties of the defendant physician against whom the expert is retained to testify?

Amicus Curiae MSMS says "yes."

d. Whether the phrase "that specialty" in the second sentence of MCL 600.2169(1)(a) should be construed to refer to the board certifications of the defendant physician against whom the expert is retained to testify?

Amicus Curiae MSMS says "yes."

STATEMENT OF FACTS

Amicus Curiae MSMS relies upon the Statement of Facts in the brief of Defendants-Appellants Otto W. Brown and Sinai Hospital in *Grossman v Brown,* and the briefs of Defendants-Appellants Raakesh C. Bhan, M.D., Critical Care Pulmonary Medicine, P.C., and Battle Creek Health Systems in *Halloran v Bhan.*

ARGUMENT

STANDARD OF REVIEW

De novo review is accorded to questions of statutory interpretation. *Roberts v Mecosta County General Hospital,* 466 Mich 57, 62; 642 NW2d 663 (2002).

I. If the Defendant is a Board Certified Specialist, MCL 600.2169 Unambiguously Requires That a Standard of Care Expert Specialize and Be Board Certified in the Same Specialty as the Defendant.

The issues raised by this appeal involve the interpretation of a statute that governs the qualification of an expert witness in a medical malpractice case against a *specialist.* The statute, MCL 600.2169, requires that an expert witness retained to give standard of care testimony for or against a defendant, specialize in the *same* specialty as the defendant if the defendant is a specialist; additionally, if the defendant-specialist is board certified, the expert must also be board certified in *that specialty*. MCL 600.2169(1)(a). Further, the expert must have devoted a majority of his or her professional time to the active clinical practice of *that specialty* and/or to the instruction of students in the *same specialty*, during the year immediately preceding the occurrence that is the basis for the claim. MCL 600.2169(1)(b).[1]

[1] MCL 600.2169(c) governs expert testimony against a general practitioner and requires that the expert, in the year immediately preceding the occurrence that is the basis for the claim,

These expert witness requirements are incorporated into MCL 600.2912d, which requires that a complaint asserting a claim for medical malpractice be accompanied by an affidavit of merit that attests to the validity of the claim. The affidavit must be signed by a health care professional that the plaintiff's attorney reasonably believes to satisfy the requirements for an expert witness prescribed by MCL 600.2169. Defendants are also required to file a similarly executed affidavit of meritorious defense. MCL 600.2912d.

Grossman v Brown

It is in the context of the affidavit of merit requirement that *Grossman v Brown* comes before this Court. In *Grossman,* plaintiff alleged the negligence of Dr. Otto W. Brown, who performed on plaintiff's decedent a left carotid artery endarterectomy that was allegedly followed by excessive post-operative bleeding. Dr. Brown was board certified in surgery and vascular surgery by the American Board of Surgery. The expert who signed plaintiff's affidavit of merit, Dr. Alex Zakharia, while board certified in surgery by the American Board of Surgery, *was not also board certified* in *vascular surgery*. Rather, Dr. Zakharia had obtained a separate board certification in *thoracic surgery* from the American Board of Thoracic Surgery. On this basis, Dr. Brown and co-defendant Sinai Hospital moved to strike and/or for partial summary disposition asserting that a properly signed affidavit of merit had not been filed. The Trial Court denied the motion, holding that Dr. Zakharia's board certification in surgery was sufficient, and that plaintiff's counsel had a reasonable belief that Dr. Zakharia met the MCL 600.2169 requirements. The Court of Appeals denied defendants'

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have devoted a majority of his or her professional time to active clinical practice as a general practitioner or to the instruction of students.

application for leave to appeal. This Court granted leave to appeal by order dated March 25, 2003.

Although various issues are presented by *Grossman*, the overriding question is whether the statute's matching board certification requirement extends to Dr. Brown's additional board certification in vascular surgery, a clearly applicable certification that Dr. Zakharia does not possess.[2] Under the plain language of the statute, the answer is clearly yes.

Halloran v Bhan

Halloran v Bhan raises similar issues in the context of a motion to strike plaintiff's expert witness. In *Halloran,* plaintiff alleged that Dr. Raakesh C. Bhan failed to properly assess and treat the condition of plaintiff's decedent, who came into the emergency room at Battle Creek Health Systems with end-stage liver failure and, upon consultation with Dr. Bhan, was admitted by Dr. Bhan to the intensive care unit. Dr. Bhan is board certified in internal medicine by the American Board of Internal Medicine ("ABIM") and has a certificate of added qualification in critical care medicine from that same board. He practices intensive care medicine. Plaintiff's standard of care expert, Dr. Thomas Gallagher, is not board certified or board eligible in internal medicine and has no training as an internist. Rather, Dr. Gallagher is board certified in anesthesiology by the American Board of Anesthesiology ("ABA") and has a certificate of added qualification from that board in critical care medicine.

Given this mismatch of board certifications, defendants moved to strike Dr. Gallagher as an expert. Defendants noted that the ABIM added qualification examination which Dr. Bhan completed to obtain his certificate of added qualification in critical care, was entirely

[2] According to the Brief of Defendants-Appellants, the Complaint alleged that Dr. Brown held himself out as a specialist in vascular surgery and owed plaintiffs' decedent "the recognized

different from the added qualification examination offered by the ABA, in that it was bsed on training and knowledge specific to internal medicine. Defendants argued that Dr. Gallagher would not have been qualified to sit for the ABIM exam.

The Trial Court granted defendants' motion, ruling that Dr. Gallagher was not qualified to give expert testimony against Dr. Bhan because they were not board certified in the same primary specialty. Upon leave granted, the Court of Appeals reversed in an unpublished, non-unanimous decision. Signed by Judges Fitzgerald and Markey, the majority almost exclusively relied upon a prior decision in *Tate v Receiving Hospital,* 249 Mich App 212; 642 NW2d 346 (2002), where an expert witness who specialized and was board certified in internal medicine was permitted to testify against a defendant who was board certified in internal medicine *and several other specialties.* The plaintiff in *Tate* argued that this was appropriate because the medical malpractice occurred during the practice of internal medicine and not during the practice of the other specialties. The *Tate* Court agreed, stating that the "use of the phrase 'at the time of the occurrence that is the basis for the action' clearly indicates that an expert's specialty is limited to the actual malpractice." *Tate,* 249 Mich App at 218, quoted in *Halloran,* slip op at 3. The *Tate* court further noted the statute's use of the word "specialty" rather than "specialties" implies "that the specialty requirement is tied to the occurrence of the alleged malpractice and not unrelated specialties that a defendant physician may hold." *Id.* The *Tate* court concluded that MCL 600.2169 could not be interpreted to require "an exact match of every board certification held by a defendant physician" and that a perfect match requirement would make "it virtually impossible to bring a medical malpractice case." *Id.* at 219. The *Tate* court thus held that "where a defendant physician has several

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standard of practice or care within that specialty," citing *Grossman* Appendix, pp 4a, ¶ 2 and

board certifications and the alleged malpractice only involves one of these specialties, § 2169 requires an expert witness to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice." *Id.* at 220.

Extrapolating from the *Tate* opinion despite the drastically different facts, the Court of Appeals in *Halloran* concluded that the alleged malpractice involved critical care medicine and not the other specialties in which Dr. Bahn and Dr. Gallagher were certified. The majority said:

> There is no dispute that both defendant and Gallagher specialize in critical care medicine and are certified in critical care medicine. The fact that Dr. Gallagher lacks a board certification in internal medicine is irrelevant because plaintiff has not alleged malpractice against defendant for treatment rendered by defendant acting as an internist. ... [T]he second sentence of § 2169(1)(a), which states that "if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified *in that specialty,*" refers to the critical care specialty that serves as the basis for the action and not the specialty of internal medicine.

The Court thus concluded that because there was no board certification in critical care medicine, the board certification matching requirement did not apply.

Judge Hoekstra dissented from the majority decision in *Halloran,* insisting that Dr. Bahn's board certification in internal medicine "plainly invoked" the board certification provision of section 2169(1)(a). Judge Hoekstra added:

> Unlike the majority, I view the board certification itself, not the certificate of added or special qualification, to be the defining credential for purposes of analyzing the applicability of the second sentence of section 2169(1)(a).

Judge Hoekstra also deemed the majority's reliance on *Tate* to be misplaced because "the operative board certifications of the two doctors at issue in *Tate* were the same. Here, they are

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8a, ¶ 36. Dr. Brown's vascular surgery specialty is clearly relevant to the Complaint.

different." Defendants moved for rehearing of the *Halloran* decision, which was denied. This Court thereafter granted leave to appeal and directed that the case be argued and submitted with *Grossman.*

The overriding issue in *Halloran,* like *Grossman*, queries the scope of the matching board certification requirement: is an expert qualified to testify if the defendant is board certified in one specialty and the expert is board certified in another, merely because they each have a certificate of added qualification in critical care medicine from their respective specialty boards? Again, based on the plain language of the statute, the answer is clearly no.

Other Pending Cases

Grossman and *Halloran* are not the only pending cases that raise these issues. This Court has ordered that applications for leave to appeal in several other cases be held in abeyance pending decision in *Grossman* and *Halloran*. These cases include *Watts v Canady,* 253 Mich App 468; 655 NW2d 784 (2002), held in abeyance, 2003 Mich LEXIS 1074, 662 NW2d 757; *Piontek v Armstrong,* 2002 Mich App LEXIS 2311, held in abeyance, 2003 Mich LEXIS 1320, 664 NW2d 221 and *Kirkaldy v Rim,* 251 Mich App 570; 651 NW2d 80 (2002), held in abeyance, 2003 Mich LEXIS 946, 661 NW2d 582.

In *Watts,* the defendant physician specialized and was board certified in pediatric neurosurgery. Plaintiff's expert was a board certified neurosurgeon. In seeking summary disposition, defendants argued that because of the differing specialties, the expert was not qualified under MCL 600.2169(1)(a). Defendants also argued that the expert was not qualified under MCL 600.2169(1)(b) because he did not devote the majority of his professional time to active clinical practice or instruction in that specialty. The Trial Court rejected the assertion that plaintiff's expert had to be a pediatric neurosurgeon. The Trial Court further opined that

the expert's professed familiarity with the procedure was enough to engender a "reasonable belief" in plaintiff that "the right specialist has been found, especially as the statute uses the word 'specialist,' not 'sub-specialist.'" The Court of Appeals affirmed. *Watts, supra.* As to the specialty issue, the Court said:

> Perhaps the use of the word "specialty" ... could be better defined. But we presume that the Legislature was familiar with the term "sub-specialty" when it enacted the provision, and the Legislature chose to use "specialty," not "sub-specialty." We see no grounds for imposing a sub-specialty requirement when the Legislature has spoken in terms of a specialty requirement. We note that while the line between a specialty and a sub-specialty may appear to be fuzzy, the terms can be defined precisely according to the standards set forth by the AMA.

253 Mich App at 470. *Watts* was wrongly decided. As is more fully discussed below, "specialty" is broad enough to encompass the more particularized sub-specialty field.

In *Kirkaldy, supra,* plaintiff alleged that defendant neurologists, both of whom were board certified, failed to diagnose and treat plaintiff's brain tumor. The affidavit of merit was signed by a board certified neurosurgeon. The Trial Court granted defendants' motions for summary disposition and dismissed the action with prejudice. Upon reconsideration, the dismissal order was vacated and the claims were dismissed without prejudice. On appeal, plaintiffs argued that the Trial Court erred in dismissing the complaint because their attorney reasonably believed that the expert was qualified. The Court of Appeals disagreed stating that the expert had to be a board certified neurologist.[3]

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[3] The Court of Appeals also rejected the assertion that plaintiffs' attorney had a reasonable belief that the expert was qualified because at the time of filing the complaint, a panel of the Court of Appeals had found MCL 600.2169 to be unconstitutional in *McDougall v Schanz,* 461 Mich App 15; 597 NW2d 148 (1999).The Court said that the decision in *McDougall* did not address or render invalid the affidavit of merit requirements of MCL 600.2912d. Further, even if such a proposition were to be accepted, this Court had granted leave to appeal the *McDougall* decision before the complaint in *Kirkaldy* was filed. The Court of Appeals affirmed the Trial Court's dismissal of the complaint without prejudice.

Finally, in *Piontek, supra,* the defendant physician performed surgery on plaintiff's decedent, related to an abdominal aneurysm. The surgery was allegedly followed by significant post-operative difficulties and a colon perforation was allegedly identified but not repaired. The defendant physician was board certified in cardiovascular thoracic surgery. Plaintiff's expert was board certified in general surgery. Defendants moved for summary disposition asserting both that the affidavit of merit was faulty and that the expert should be stricken as unqualified. The Trial Court denied summary disposition based upon the affidavit of merit because plaintiff's attorney could have reasonably believed the expert to be qualified. However, the Trial Court granted the motion to strike and for summary disposition on the basis that the expert was not qualified under MCL 600.2169. The Court of Appeals reversed this later ruling, stating:

> It is clear from plaintiff's complaint that plaintiff's theory of the case is predicated on the actions of appellee during the course of the decedent's post-operative care. Specifically, plaintiff alleges that appellee failed to timely recognize, diagnose, and treat a bowel ischemia that eventually led to a perforation of the bowel. This allegation of malpractice does not involve the actual surgery on the decedent's abdominal aorta. We believe that the post-operative care of the decedent falls under the broad specialty of general surgery, particularly where the condition that led to the decedent's death is unrelated to the scope of the surgery performed. ...

2002 Mich App LEXIS 2311 at * 8-9. This case, too, ignores the plain language of the expert witness statute.

Interest of Michigan State Medical Society

Each of these cases present issues of concern to Michigan State Medical Society ("MSMS"). As a professional association that represents the interests of over 14,000 physicians in the State of Michigan, MSMS has a pervasive interest in assuring that standard of care witnesses be trained and appropriately credentialed in the fields in which they testify.

The rapid advancement of medical science has necessitated increasing efforts by the medical profession to insure that physicians are properly trained in their practice areas. This frequently requires multiple levels of specialized training and certification within a particular field of medicine. Whether these increasingly particularized fields are deemed specialties or sub-specialties is only a matter of semantics. It is the substantive course of training, certification, and experience in a specialty field that is important.

The Legislature has already determined that, to insure the reliability of an expert's standard of care testimony, the specialties and board certifications of the expert and the defendant must be the *same*. Relevant and related specialties, and concomitantly relevant and related board certifications, do not suffice. This appropriately reflects the stringency of real world practice. Medicine has extensively evolved into specialties and subspecialties. The American Board of Medical Specialties ("ABMS") consists of 24 member boards which develop and utilize professional and educational standards for the training, evaluation and credentialing of physicians in their respective specialty areas. Hospitals rely upon the credentialing and certification by the ABMS boards, as well as other certifying boards, such as the American Board of Oral and Maxillofacial Surgery, the American Board of Clinical Neurophysiology, and the American Society of Echocardiography, to screen, select, appoint and award hospital privileges to physicians. In some hospitals, for example, a board certified neurologist cannot perform or interpret epilepsy monitoring absent additional certification by the American Board of Clinical Neurophysiology. As another example, a physician who does high level invasive cardiology and is certified in both interventional cardiology and regular cardiology may not have the privilege of performing transesophageal echocardiography if he is not trained or certified in that procedure. A physician who lacks the training, experience

and certification required to be credentialed by a hospital to perform a certain procedure or practice a particular specialty is certainly not qualified to articulate the standard which governs that procedure or specialty in a court of law. MCL 600.2169, with its attention to the specialties and certifications of the defendant, is a recognition of this realty.

The "standard of care" is a key element to the prosecution and defense of a medical malpractice case. Unlike the ordinary tort duty of "reasonable care," physicians must conform to the standard of care customarily exercised by other physicians in the locality. In Michigan, the standard of care applicable to medical malpractice actions has been codified. MCL 600.2912a provides:

> In an action alleging malpractice the plaintiff shall have the burden of proving that in light of the state of the art existing at the time of the alleged malpractice:
>
> (a) The defendant, if a general practitioner, failed to provide the plaintiff the recognized standard of acceptable professional practice or care in the community in which the defendant practices or in a similar community, and that as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.
>
> (b) The defendant, if a specialist, failed to provide the recognized standard of practice or care within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonable available under the circumstances, and as a proximate result of the defendant failing to provide that standard, plaintiff suffered an injury.[4]

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[4] In *Cox v Board of Hospital Managers for the City of Flint,* 467 Mich 1; 651 NW2d 356 (2002), this Court noted that the standard of care for specialists is frequently, but inaccurately referred to as a national standard of care. This Court explained:

> The plain language of subsection (b) states that the standard of care is that "within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances." ... Under the plain language of the statute, then, the standard of care for both general practitioners and specialists refers to the community."

Id. at 19 n 17. That issue is not raised by the cases presently before this Court.

This standard must be established by an expert witness who is familiar with the customary practice of the relevant population of professionals.

As this Court recognized in *McDougall v Schanz,* 461 Mich 15, 31; 597 NW2d 148 (1999), the statute before this Court essentially modifies the standard of care element "to require that proof of malpractice 'emanate from sources of reliable character as defined by the Legislature", quoting then Judge Taylor's dissenting Court of Appeals' opinion in *McDougall,* 218 Mich App at 518. That wasn't always the case. Prior to 1986, MRE 702 was the sole determinant regarding the admissibility of expert testimony. The rule permits a witness to give expert testimony if the witness is "qualified as an expert by knowledge, skill, experience, training, or education ..." This standard gave Michigan courts fairly free reign to determine whether a proffered expert had the requisite familiarity with the standard of care to past evidentiary muster. Indeed, familiarity with the standard of care was frequently articulated as the qualifying test. *See e.g., Dybata v Kistler,* 140 Mich App 65, 69; 362 NW2d 891 (1985); *Bahr v Harper-Grace Hospitals,* 198 Mich App 31, 34-35; 497 NW2d 526 (1993); *Siirila v Barrios,* 398 Mich 576, 593; 248 NW2d 171 (1976); *Francisco v Parchment Medical Clinic, P.C.,* 407 Mich 325, 327; 285 NW2d 39 (1979); *Callahan v William Beaumont Hospital,* 400 Mich 177, 180; 254 NW2d 31 (1977).

While courts traditionally examined the *specialty* of the defendant when determining whether the proffered expert was qualified to testify under MRE 702, the absence of specific guidelines led to an obvious lack of uniformity. Some courts found that an expert who did not specialize in the same field as the defendant was not sufficiently familiar with the applicable standard of care to testify. *See e.g., Swantek v Hutzel Hospital,* 115 Mich App 254, 259; 320 NW2d 234 (1982)(pediatric neurologist could not testify as to the standard of care of an

obstetrician-gynecologist); *Dybata v Kistler, supra* (obstetrician-gynecologist is not sufficiently familiar with the standard of care governing a general practitioner); *Carlton v St John Hospital,* 182 Mich App 166; 451 NW2d 543 (1989)(even though witness need not specialize in the field he is asked to testify about, cardiologist was not qualified to opine whether performance of surgery violated the standard of care applicable to a surgeon); *Dunn v Nundkumar,* 186 Mich App 51; 463 NW2d 435 (1990)(even though expert need not specialize in the field he is asked to testify about, general surgeon and family practitioner was unqualified to testify regarding the standard of care governing an obstetrician-gynecologist). *See also, Dengler v State Farm Mutual Ins Co,* 135 Mich App 645; 354 NW2d 294 (1984)(proffered expert who was not a specialist in neurology was not qualified to testify regarding a subarachnoid hermorrhage).

Other courts allowed expert witnesses to testify even absent credentials or experience in the defendant's *specialty*. *See e.g., Wolak v Walczak,* 125 Mich App 271, 276; 335 NW2d 908 (1983)(obstetrician-gynecologist may testify about the effect of bilirubin in newborns); *Strach v St. John Hospital Corp,* 160 Mich App 251; 408 NW2d 441 (1987)(board certified general surgeon permitted to testify against a thoracic surgeon); *Banks v Wittenberg,* 82 Mich App 274; 266 NW2d 788 (1978)(urologist can testify regarding the standard of care applicable to a general practitioner); *Wilson v W A Foote Memorial Hospital,* 91 Mich App 90; 284 NW2d 126 (1979)(orthopedic surgeon permitted to testify regarding the standard of care of a hospital relative to the emergency nature of a breech presentation at birth); *Mazey v Adams,* 191 Mich App 328; 477 NW2d 698 (1991)(internist with specialty in cardiology permitted to testify to standard of care of general practitioner); *Siirila v Barrios, supra,* and *Berwald v*

Kasal, 102 Mich App 269; 301 NW2d 499 (1980)(specialist may testify as to standard of care applicable to a general practitioner).

There was also a discrepancy in the requisite timeliness of the expert's knowledge. Some courts allowed experts to testify despite their absence from the practice of medicine for a number of years. *See e.g., Pietrzyk v Detroit,* 123 Mich App 244; 333 NW2d 236 (1983)(medical doctor's 20-year absence from the emergency room setting did not preclude him from testifying about the standard of care in an emergency room); *Haisenleder v Reeder,* 114 Mich App 258; 318 NW2d 634 (1982)(physician who had not practiced for 13 years in an emergency room setting was permitted to testify regarding the standard of care applicable to an emergency room physician). Other experts were disqualified because of their absence from practice. *Gilmore v O'Sullivan,* 106 Mich App 35; 307 NW2d 695 (1981) (an expert who had not delivered a baby since 1959 nor performed surgery since 1967 could not testify regarding the standard of care applicable to an obstetrician-gynecologist).

Not surprisingly, these amorphous requirements for standard of care testimony led to a proliferation of circuiting-riding "experts" who "practiced" only in the litigation arena. Their "pay-for-what-you-want testimony" compromised the integrity of the judicial process and contributed to the malpractice crisis that prompted the need for tort reform. As the *Report of the Senate Select Committee on Civil Justice Reform* viewed the problem in Michigan:

> Testimony of expert witnesses is normally required to establish a cause of action for malpractice. Expert testimony is necessary to establish both the appropriate standard of care and the breach of that standard. There is currently no specific requirement for an expert witness to devote a specific percentage of time to the actual practice of medicine or teaching, or when testifying against a specialist that the expert actually practices or teaches in *that specialty*. Instead, a physician-witness is qualified to testify as an expert in Michigan, even though he/she does not practice in Michigan and is not of the same specialty, based on a mere showing of an acceptable background and a familiarity with the nature of the medical condition involved in the case. As a practical matter, in many

> courts merely a license to practice medicine is needed to become a medical expert on an issue.
>
> This has given rise to a group of national professional witnesses who travel the country routinely testifying for plaintiffs in malpractice actions. These "hired guns" advertise extensively in professional journals and compete fiercely with each other for the expert witness business. For many, testifying is a full-time occupation and they rarely actually engage in the practice of medicine. There is a perception that these so-called expert witnesses will testify to whatever someone pays the [sic] to testify about.

Id. at 28-29 (emphasis added).[5]

To address this problem, the 1986 enactment of MCL 600.2169 required that expert witnesses "actually practice" or "teach medicine" and have "firsthand practical expertise in the subject matter about which they are testifying." *Id.* The *Senate Report* explained:

> In particular, with the malpractice crisis facing high-risk specialists, such as neurosurgeons, orthopedic surgeons and ob/gyns, this reform is necessary to insure that in malpractice suits against specialists, the expert witnesses actually practice in that same specialty. This will protect the integrity of our judicial system by requiring real experts instead of "hired guns."

Id. at 29.

The 1986 version of the statute sought to do this by requiring that an expert testifying for or against a specialist, specialize in the same specialty *or a related relevant area of medicine* as the defendant in the action, and devote or have devoted at the time of the occurrence involved in the action, a substantial portion of his or her professional time to practice or teaching in that area.[6] The statute provided in relevant part:

> (1) In an action alleging medical malpractice, if the defendant is a specialist, a person shall not give expert testimony on the appropriate standard of care unless the person is or was a physician licensed to

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[5] This report is included in several of the parties' appendices.

[6] The statute was enacted as part of the Michigan Tort Reform Act of 1986, P.A. 1986, No. 178.

practice medicine or osteopathic medicine and surgery or a dentist licensed to practice dentistry in this or another state and meets both of the following criteria:

(a) Specializes, or specialized at the time of the occurrence which is the basis for the action, *in the same specialty or a related, relevant area of medicine or osteopathic medicine and surgery or dentistry as the specialist who is the defendant* in the medical malpractice action.

(b) Devotes, or devoted at the time of the occurrence which is the basis for the action, a substantial portion of his or her professional time to the active clinical practice of medicine or osteopathic medicine and surgery or the active clinical practice of dentistry, or to the instruction of students in an accredited medical school, osteopathic medical school, or dental school *in the same specialty or a related, relevant area of health care as the specialist who is the defendant* in the medical malpractice action.

* * *

Former MCL 600.2169 (emphasis added).

Although the 1986 statute tightened up the requirements for the qualification of experts, it was soon felt that the statute had not gone far enough and that more restrictive reforms were necessary. Thus, the 1993 amendments required that the proffered expert be currently licensed to practice medicine, practice in the *same specialty* as the defendant, and be *board certified in that specialty if the defendant was board certified.* The revised statute further required that the expert devote the majority of his or her professional time to practice or instruction in that specialty. The statute, which is the statute presently before this Court, provides in pertinent part:

(1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:

(a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

(b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:

(i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.

(ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

* * *

In *McDougall v Schanz,* 461 Mich 15; 597 NW2d 148 (1999), this Court upheld the expert witness statute as a valid exercise of the Legislature's public policy-making prerogative, finding that the statute did not impermissibly infringe upon this Court's exclusive authority under the Michigan Constitution 1963, art 6, § 5, to promulgate rules governing

practice and procedure in Michigan courts. Rather, this Court concluded that the statute was an enactment of "substantive law." 461 Mich at 18.[7] This Court explained:

> [W]e conclude that § 2169 is an enactment of substantive law. It reflects wide-ranging and substantial policy considerations relating to medical malpractice actions against specialists. We agree with the Court of Appeals dissent in *McDougall* that the statute
>
> > reflects a careful legislative balancing of policy considerations about the importance of the medical profession to the people of Michigan, the economic viability of medical specialists, the social costs of "defensive medicine," the availability and affordability of medical care and health insurance, the allocation of risks, the costs of malpractice insurance, and manifold other factors, including, no doubt, political factors – all matters well beyond the competence of the judiciary to reevaluate as justiciable issues. [218 Mich. App. at 518 (Taylor, P.J., dissenting).]

461 Mich at 29-30.

Each of the above observations remains true today. The plain language of the statute is not enigmatic but the Court of Appeals in *Halloran* and the Trial Court in *Grossman* elected to interpret the statute in a manner that reflects their own opposing policy choices rather than those of the Legislature. In so doing, these courts have exceeded the judicial restraints on statutory construction and contorted the applicable rules of statutory construction. It seems clear that this Court's articulation of the issues it has deigned to consider presents the urgently needed opportunity to bring application of the statute back to the fold of its intended meaning. It is to this meaning, that MSMS now turns.

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[7] The 1986 version of the statute was before this Court in *McDougall*. However, this Court stated that its ruling applied with equal force to the 1993 statute. 461 Mich at 21, n 2.

A. The Rules of Statutory Construction Require that the Statute be Applied According to its Plain Meaning.

This Court recently articulated and observed the applicable rules of statutory construction in *In re Certified Question, Henes Special Projects Procurement, Marketing and Consulting Corp v Continental Biomass Industries, Inc,* 468 Mich 109; 659 NW2d 597 (2003), a case certified by the Sixth Circuit to determine the standard for evaluating the mental state required to assess double damages under the Michigan Sales Representative Commission Act. In addressing the issue, this Court explained:

> A fundamental principle of statutory construction is that "a clear and unambiguous statute leaves no room for judicial construction or interpretation." *Coleman v Gurwin,* 443 Mich 59, 65; 503 NW2d 435 (1993). The statutory language must be read and understood in its grammatical context, unless it is clear that something different was intended. *Sun Valley Foods Co v Ward,* 460 Mich 230; 596 NW2d 119 (1999). When a legislature has unambiguously conveyed its intent in a statute, the statute speaks for itself and there is no need for judicial construction; the proper role of a court is simply to apply the terms of the statute to the circumstances in a particular case. *Turner v Auto Club Ins Ass'n,* 448 Mich 22, 27; 528 NW2d 681 (1995).

See also, Eggleston v Bio-Medical Applications of Detroit, Inc, 468 Mich 29; 658 NW2d 139 (2003)("If the language of a statute is clear, no further analysis is necessary or allowed."); *Roberts v Mecosta County General Hospital,* 466 Mich 57, 63; 642 NW2d 663 (2002)("a court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statute itself."); *Omelenchuck v City of Warren,* 461 Mich 567, 575; 609 NW2d 177 (2000)(refusing to rewrite the tolling statute to add words to the statute); *Sun Valley Foods Co v Ward*, 460 Mich. 230, 236; 596 NW2d 119 (1999)(the Court's primary task of discerning and giving effect to the Legislative intent "begins by examining the language of the statute itself."); *People v Herron,* 464 Mich 593, 611; 628 NW2d 528 (2001)("We must give the words of a statute their plain and ordinary meaning

....")(quoting *People v Morey*, 461 Mich 325, 329-30; 603 NW2d 250 (1999)); *Storey v Meijer, Inc*, 431 Mich 368, 376; 429 NW2d 169 (1988)("Legislative intent is to be derived from the actual language of the statute, and when the language is clear and unambiguous, no further interpretation is necessary.").

The judiciary may not engage in legislation, *Roberts, supra* at 66, nor speculate about the Legislature's intent beyond the words expressed. *Rheaume v Vandenberg,* 232 Mich App 417, 422; 591 NW2d 331 (1998). The judicial role "precludes imposing different policy choices than those selected by the Legislature." *The Herald Co v City of Bay City,* 463 Mich 111, 117; 614 NW2d 873 (2000). As this Court explained in *Hanson v Board of County Road Commissioners of the County of Mecosta,* 465 Mich 492, 504; 638 NW2d 396 (2002):

> [O]ur function is not to redetermine the Legislature's choice or to independently assess what would be most fair or just or best public policy.

Where the Legislature has not expressly defined common terms used in a statute, the Court may consider dictionary definitions to construe those words in accordance with their ordinary and generally accepted meanings. *In re Certified Question,* 468 Mich at 113. A word or phrase also derives meaning from its context or setting. *The Herald Co, supra* at 131.

These rules leave no doubt as to the proper application of MCL 600.2169. An expert must devote the majority of his professional time to practice or instruction in the same specialty as the defendant, and if the defendant is board certified in that specialty, the expert must be board certified in that same specialty. Several courts have construed the statute to require a precise match. For example, in *Greathouse v Rhodes,* 242 Mich App 221; 618 NW2d 106 (2000), reversed on other grounds, 465 Mich 885; 636 NW2d 138 (2001), the Court of Appeals deemed MCL 600.2169 to require "that the expert's practice, teaching and certification qualifications be precisely 'matched' with those of the defendant." In *Kirkaldy,*

251 Mich App at 577, the Court of Appeals interpreted MCL 600.2169 to require that the expert practice or teach "in the same specialty as the defendant" and if the defendant is board certified in a specialty, "the expert must be board certified in *that same specialty.*" (emphasis added). As the Court of Appeals saw it in *Decker v Flood,* 248 Mich App 75, 85; 638 NW2d 163 (2001), there was "no absurdity or unreasonableness in the requirement that the qualifications of a purported expert match the qualifications of the defendant against whom that expert intends to testify." Even the dissent in *McDougall* acknowledged that "the statute requires a specialist for specialist 'match-up' between witnesses and defendants." 461 Mich at 67 (Cavanagh, J, dissenting). *See also, Shenduk v Harper Hospital,* 1999 Mich App LEXIS 2571, *21 (1999)(Murphy J, concurring and dissenting)("As drafted, the statute clearly requires that when a defendant has board certification in a particular specialty an expert witness must hold matching board certification"); *Kyser v Hillsdale Community Health Center,* 2003 Mich App LEXIS 1757, *3 (2003)(concluding that the fact that the defendant-board certified specialist in internal medicine was acting as an emergency room doctor is irrelevant because the statute "provides that an expert must specialize 'in the same specialty' as the defendant doctor, not that he must specialize in the area of medicine being practiced by the defendant doctor at the time the cause of action arose."). A proper analysis of the statute confirms the propriety of these decisions. [8]

[8] As discussed above, certain panels of the Court of Appeals have reached contrary results. In *Tate*, the Court of Appeals held that the expert need only match the specialty involved in the action, not the defendant's unrelated specialties. Multiple unrelated specialties are not presented by the cases before this Court. In *Watts,* the Court of Appeals held the matching requirement did not apply to "sub-specialties." In *Piontek,* a general surgeon was permitted to testify against a specialist in cardiovascular thoracic surgery. And, in *Halloran,* it was enough that the defendant and the expert possessed certificates of added qualification in critical care medicine, even though the defendant specialized in internal medicine and the expert specialized in anesthesiology. MSMS believes that in each of these cases, the Court failed to

B. To Effectuate the Plain Meaning of the Statute, the Word "Specialty" in the First Sentence of MCL 600.2169(1)(a) Must be Construed to Require that the Training and Particularized Specialty Practice Areas of the Defendant and the Expert are the Same.

The first enacted version of MCL 600.2169 permitted the proffered expert to practice in an area of medicine that was "related" and "relevant" to the defendant's specialty. This meant that a specialist in one field could testify against a specialist in another field "as long as the two fields were connected to each other and had practical value to one another and as long as the proposed expert practiced or taught in the associated, pertinent area of health care." *McClellan v Collar,* 240 Mich App 403, 410; 613 NW2d 729 (2000).

The 1993 amendment eliminated this leeway by requiring that the expert specialize in the same specialty as the defendant. This Court has characterized the 1993 statute as "more restrictive" than the 1986 version. *McDougall v Schanz,* 461 Mich at 21, n2. Other Courts have reached the same conclusion. *See e.g., McClellan v Collar,* 240 Mich App at 408 ("The 1993 amendments are more restrictive than the requirements set out in the version of § 2169 that applies to this case"); *Shenduk v Harper Hospital,* 1999 Mich App LEXIS at *24 (1999)(Murphy J, concurring and dissenting)("the increased restriction of the current 1993 version, not allowing for specialists of a *related* discipline, indicates that strict adherence is intended.").

Because a change in the language used in a statute is presumed to reflect a change in its meaning, *Michigan Millers Mutual Ins v West Detroit Building Co, Inc,* 196 Mich App 367, 373; 494 NW2d 1 (1992), ***there can be no doubt that the 1993 amendment requires precise***

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apply the expert witness statute as written, but rather imposed their own policy preferences under the guise of judicial construction.

exactitude. Anything less would call back the "relevant, related" language of the superceded statute.

Rather, the more precise issues raised by *Grossman* and *Halloran* center upon the scope of the matching requirement and the impact of more particularized specialization in an area of medicine. Is an expert qualified to testify if his specialty matches but his more particularized specialization does not? (*Grossman)*? What if the more particularized specialty practice areas match but they derive from primary specialties that do not? (*Halloran).* These questions can be consistently answered by responding to this Court's first question: how should the word "specialty" in the first sentence of Section 2169(1)(a) be construed?

Nothing in the commonly accepted meanings of "specialty" or "specialist" precludes attention to particularization. Indeed, particularity is the hallmark of specialization. In *Cox v Board of Hospital Managers for the City of Flint,* 467 Mich 1, 18, this Court quoted the *Random House Webster's College Dictionary* (1997) of specialist as "a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc." *See also, Decker v Flood,* 248 Mich App 75; 638 NW2d 163 (2001) (quoting same *Random House Webster's College Dictionary* (1997) definition, as well as the *Stedman's Medical Dictionary* (26th ed) definition which defines specialist as "one who devotes professional attention to a particular specialty or subject area." The dissenting opinion in *Cox* stated that a specialist "is classified as such by virtue of advanced training, not merely by having concentrated in a specific area of practice." 467 Mich at 54. A similar definition was employed in *Jalaba v Borovoy,* 206 Mich App 17, 22; 520 NW2d 349 (1994), where the Court of Appeals observed that a doctor is a specialist "on the basis of advanced training and expertise in a particular field of general medicine."

The meaning of "specialty" is certainly broad enough to encompass more particularized training, qualifications, and practice areas, sometimes referred to as sub-specialties. A sub-specialty is, after all, simply further specialization. The statute does not expressly limit its scope to *primary* specialties or expressly exclude *sub* specialties. Nothing in the statute evidences an intent to impose such a limitation. Thus, the matching requirement, as applied to *Grossman,* does not end at the shared specialty of general surgery. Dr. Brown also specialized in, and was additionally certified in *vascular surgery* by the American Board of Surgery. Plaintiff's expert, Dr. Zakharia, was not board certified in *vascular surgery*. Rather, Dr. Zakharia had additional training in, specialized in, and was board certified in *thoracic surgery* (by the American Board of Thoracic Surgery). These may be related or relevant specialties but they are not "the same." Dr. Zakharia is not qualified to testify against Dr. Brown.

Similarly, the possession of certificates of added qualification in critical care medicine from the governing boards of differing specialties (internal medicine vs. anesthesiology) does not satisfy the "same specialty" requirement in *Halloran.* Dr. Gallagher is an anesthesiologist by training. Dr. Bhan is an internist by training. It is the training, experience and credentialing which makes one a specialist. Dr. Gallagher does not specialize in internal medicine and cannot testify against Dr. Bhan.

This stringent prohibition against specialty-crossing with respect to standard of care testimony exists for very practical and recognized reasons. As the United States District Court for the Western District of Michigan explained in applying the 1986 statute:

> Plaintiff would of course like to have an orthopedic surgeon testify as to the defendant's standard of care, since now, in hindsight, we know that plaintiff sustained a fractured bone. Had plaintiff been seen initially by an orthopedic surgeon, that physician would have been held to the standard of care applicable

> to an orthopedic surgeon . . . It is certainly likely that an x-ray would have ordered by an orthopedic surgeon – since that is what orthopedic surgeons do to assess the orthopedic health of their patients. Had plaintiff been seen initially by an infectious disease specialist, perhaps laboratory cultures of the wound would have been ordered. Had plaintiff been seen initially by a plastic surgeon, perhaps the wound would have been closed differently and with less scarring. But, plaintiff was not seen by any of these specialists. Rather, plaintiff sought the advice of a family practitioner. Under Michigan law, a family practitioner cannot be held to the standard of care of these other specialties.

Cronkrite v Fahrbach, 853 F Supp 257, 261 (WD Mich 1994). The meaning of the statute is clear and it must be applied as written. Only an expert who specializes in the same specialty as the defendant can overcome the initial qualification hurdle.

C. To Effectuate the Legislative Intent, the Phrase "That Specialty" in the Second Sentence of MCL 600.2169(1)(a) Must Be Construed to Require that the Expert be Board Certified in the Same Specialty that the Defendant is Board Certified In.

Words derive meaning from the "context or setting" in which they are used. *Macomb County Prosecuting Attorney v Murphy,* 464 Mich 149, 159; 627 NW2d 247 (2001). Thus, to interpret the meaning of "that specialty" in the second sentence of MCL 600.2169(1)(a), this Court must consider "its placement and purpose in the statutory scheme." *Sun Valley Foods Co v Ward,* 460 Mich 230, 237; 596 NW2d 119 (1999).

The second sentence of MCL 600.2169(1)(a) follows the requirement that the expert specialize in the same specialty as the defendant. Thus, the board certification requirement in the second sentence of Section 2169(1)(a) will not be triggered unless the expert and the defendant specialize in the same field. If matching specialties have been established, the added board certification requirement - the second sentence requirement - must be satisfied. This sentence provides:

> However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

This added requirement can only mean that the expert must possess the same board certifications as the defendant. This is only logical as the dfendant and expert are already required to practice the same specialty.[9]

It is patently clear that there is no support in the statute for the result reached by the Court of Appeals in *Tate v Receiving Hospital.* Nothing in the phraseology of the second sentence of (1)(a) limits the matching board certification requirement to the specialty out of which the claim for malpractice arose. The "at the time of the occurrence that is the basis for the action" language in the first sentence is simply a temporal requirement. It specifies that the specialty of the defendant at the time of the occurrence and the specialty of the expert at the time of the occurrence must be the same. It does not say that the matching specialties requirement relates to the specialty involved in the claim, much less limit the matching requirement to the involved specialty area.

Equally specious is the reliance of the *Tate* court on the use of the singular "specialty." The court cited this observation in support of its holding that the matching requirement only applied to the specialty involved in the claim. However, the court's narrow interpretation of the "specialty" reference ignores a statutory rule of construction which provides that "[e]very word importing the singular number only may extend to and embrace the plural number, and every word importing the plural number may be applied and limited to the singular number." MCL 8.3b. *See also, Crowley-Milner & Co v Macomb Circuit Judge,* 239 Mich 605; 215 NW 29 (1927)(the word "judge" as used in statute regarding the disqualification of judges, should be read "judges.")

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[9] Thus, even if "that specialty" referred to the specialty in which the expert witness specialized, by virtue of the first sentence-matching specialties requirement, the result would be the same.

Further, when the same word or phrase is used in different parts of a statute, it is presumed to have the same meaning throughout. *See Phipps v Campbell, Wyant & Cannon Foundry,* 39 Mich App 199; 197 NW2d 297 (1972). The phrase "that specialty" is also used in Section 2169(1)(b)(i) which states:

> Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of *that specialty.*

MCL 600.2169(1)(b)(i) (emphasis added). This reference clearly refers to the specialty of the defendant. Section 2169(1)(a) requires the same interpretation.

The result reached by the Court of Appeals in *Halloran* and by the Trial Court in *Grossman* is thus contrived. The board certification is a representation of the training and qualifications of the holder. If a primary board certification matches but the more particularized board certifications do not, the requirement of the statute has not been fulfilled. Thus in *Grossman,* it is not enough that the defendant and the expert are each board certified by the American Board of Surgery. The defendant possesses an additional certification in vascular surgery that the expert does not possess. The expert's further certification is in thoracic surgery. This end-line mismatch is determinative. The expert is not certified in the same specialties as the defendant. He cannot testify.

Nor does a match exist in *Halloran.* First, certificates of added qualification in critical care medicine issued by different specialty practice boards are not matching "board certifications." They are issued by different boards, which represent separate and distinct

branches of medicine, each with its own training and credentialing programs. Second, the added qualification certificates cannot be used to jump over or cancel the mismatched board certifications of the defendant and expert's primary specialties. The expert's board certification in anesthesiology is not a match for Dr. Brown's board certification in internal medicine. These differing certifications are indicative of significant differences between the defendant's training and qualification, differences that the amended statute was designed to eliminate. Under the plain language of the statute, the board certification requirement has not been met in either of these cases

CONCLUSION AND RELIEF REQUESTED

The specialty and board certification differences between the defendants and their opposing experts are well-documented in these cases. It is equally clear that "related" or "relevant" specialties and board certifications do not suffice. To the contrary, in the serious business of medical malpractice litigation the Legislature has directed, as a matter of substantive law, that the specialties and board certifications of the defendant and the expert be the "same." It is not for this Court to dilute the statute's requirements. To the contrary, it is the duty of this Court to insure that the statute's requirements are properly enforced.

Amicus Curiae Michigan State Medical Society therefore joins Defendants-Appellants' request for relief and urges this Court to reverse the Court of Appeals' decision in *Halloran v Bhan* and reverse the Trial Court's order denying Defendants' Motion to Strike and for Partial Summary Disposition in *Grossman v Brown*.

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